# AFFORDABLE CARE ACT
# MASSACHUSETTS IMPLEMENTATION UPDATE

## March 28, 2012

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These Updates, published by the Executive Office of Health and Human Services (EOHHS) in consultation with the other state agencies involved in ACA implementation, will bring you news related to the implementation of provisions of the ACA here in Massachusetts.

## Grants and Demonstrations

The ACA provides funding opportunities to transform how health care is delivered, expand access to care and support healthcare workforce training.

## Grant Announcements

**Advanced Nursing Education Program, §5308**. Announced March 26, 2012. Funding is available to educate registered nurses to become advanced nurse specialists, i.e. nurses trained in advanced degree programs including nurse practitioners, nurse midwives, and nurse administrators. Proposed programs must integrate the development and incorporation of technology and should also engage other health professions into the nursing curriculum through an inter-professional education model. $9M annually for three years in 24 awards is available. Applications are due May, 18 2012.
The announcement can be viewed at: HRSA

**Advanced Education Nursing Traineeship (AENT) Program, §5308**. Announced March 22, 2012. Funding is available to provide traineeships to students who are pursing advanced degrees as primary care nurse practitioners or nurse-midwives. The traineeships will cover full or partial tuition, books, fees, and reasonable living expenses. Eligible applicants are schools of nursing, nursing centers, academic health centers, and State or local governments that offer primary care nurse practitioner and nurse-midwifery programs. $22.75M in 65 awards is available. Applications are due April, 24 2012.
The announcement can be viewed at: HRSA

**Graduate Nurse Education Demonstration, §5509**. Announced March 21, 2012.
CMS will reimburse up to five eligible hospitals for the cost of providing clinical training to

advanced practice registered nurses (APRN) students added as a result of the demonstration. The training will provide APRNs with the clinical skills to provide primary care, preventive care, transitional care, chronic care management, and other services appropriate for Medicare beneficiaries. Hospitals participating in the demonstration must partner with accredited schools of nursing and non-hospital community-based care settings. Certain hospitals, including Critical Access Hospitals that meet certain criteria as specified in the Solicitation, are eligible to apply. $200M in 5 four-year grants is available. Payments to the participating hospitals will be linked directly to the number of additional APRNs that the hospitals and their partnering entities are able to train as a result of their participation in the demonstration. Applications are due May 21, 2012.
For more information visit: http://innovation.cms.gov/initiatives/gne/
Read the fact sheet at: Fact Sheet
Read the solicitation at: Solicitation (PDF)
Read the press release at: Press Release

**Primary Care Training and Enhancement Physician Assistant Training in Primary Care Program, §5301.** Announced March 20, 2012. Funding is available to develop a primary care training and enhancement program that supports the curriculum and infrastructure for physician assistant students and teachers. Funds can be used to plan, develop and operate a program 1) for physician assistants to train in primary care settings and 2) for individuals who teach primary care in physician assistant training programs. Eligible applicants are accredited public or nonprofit private hospitals, allopathic or osteopathic schools of medicine and academically affiliated physician assistant training programs. $2.5M in 11 five-year grants is available. Applications are due May 8, 2012.

The announcement can be viewed at: HRSA

## Guidance

**3/21/12 CMS issued guidance regarding the implementation of §1104 of the ACA, Administrative Simplification and electronic health care transactions**. The information bulletin describes standards for the adoption of operating rules for eligibility for a health plan and health care claim status transactions. According to CMS, by implementing these requirements, states will improve the automation of health care administrative processes and benefit from reduced transaction costs such as reduced time and effort related to contacting physicians and health plans for resolution of claims, denial of claims, and additional postage and paperwork costs.

In July 2011 HHS published an interim final rule to adopt operating rules to support the adopted standard transactions for the eligibility for a health plan and health care claim status transactions effective January 1, 2013. Combined, the operating rules laid out in the July interim final rule and the March bulletin are expected to assist providers in receiving more robust and complete responses to their inquiries for eligibility and claim status information.
Read the interim final rule at: Final Rule

According to CMS, as stated in the March 2012 bulletin, state Medicaid agencies must conduct a gap analysis to determine if operational changes are needed to comply with the Administrative Simplification operating rules and to be able to provide the newly required information. Further, States must analyze their current Medicaid information technology infrastructure to determine if hardware and/or software modifications are needed in order to be compliant by January 1, 2013.

Federal Financial Participation (FFP) is available to states that make modifications to their Medicaid IT infrastructure in order to comply with the operating rules. However, in order to be

eligible for enhanced funding, a state's system must comply with certain standards and conditions specified by CMS through regulation.
Read the regulation regarding Federal Funding for Medicaid Eligibility Determination and Enrollment Activities (including systems work) at: http://www.gpo.gov/fdsys/pkg/FR-2011-04-19/pdf/2011-9340.pdf

Frequently Asked Questions can be viewed on CMS' Web site at: FAQ
Read the March 2012 bulletin at: Bulletin

Prior guidance can be viewed at www.healthcare.gov

## News

**3/26/12 The U.S. Supreme Court began to hear oral arguments in the multi-state lawsuit as to the constitutionality of various provisions of the ACA**. The hearing will last six hours and stretch over three days, the longest arguments in 45 years. The Supreme Court is considering four separate questions related to separate parts of the law (rather than looking at the Act as a whole). On Monday 3/26/12 the Court considered the relevance of the federal Anti-Injunction Act which prevents courts from striking down tax laws until they go into effect. If found to be relevant in this case, the Court could postpone further ruling until after 2014 because that's when the individual mandate's penalty goes into effect. Tuesday 3/27/12 the Supreme Court looked at whether the individual mandate is within the scope of Congress' power either to regulate commerce among the states or to tax and spend for the general welfare. In other words, the Court is considering whether Congress has the constitutional authority to require that nearly all Americans purchase health insurance, and whether it has the right to assess a financial penalty for those who refuse. Wednesday 3/28/12 the Court hears arguments on the issue of severability and whether it could find the individual mandate unconstitutional, while letting the rest of the ACA stand. The government says that if the court strikes down the mandate, it should also repeal the ACA's guaranteed issue and community rating provisions, which require insurers to accept all customers regardless of their health care status. They argue that without the mandate and all individuals buying insurance, premiums would increase, healthy people would defer buying insurance until they need care and insurance markets should no longer be required to accept all applicants. The 26 states that filed suit against the ACA argue that, given the way the law was written (without a clause that specifically noted that individual provisions could be severable) the whole thing should fall if the mandate is determined to be unconstitutional. Wednesday 3/28/12 the Court will also consider whether the ACA's significant expansion of Medicaid eligibility creates an unconstitutional burden on the states in violation of Congress' power under the Spending Clause and the Tenth Amendment. The Supreme Court is expected to issue its decision by the end of its term in June 2012.

The lawsuit was brought by The National Federation of Independent Business (NFIB) and 26 states including: Alabama, Alaska, Arizona, Colorado, Florida, Georgia, Idaho, Indiana, Iowa, Kansas, Louisiana, Maine, Michigan, Mississippi, Nebraska, Nevada, North Dakota, Ohio, Pennsylvania, South Carolina, South Dakota, Texas, Utah, Washington, Wisconsin and Wyoming.

More information, including transcripts and audio, is available at:
http://www.supremecourt.gov/

**3/23/12 Donald M. Berwick, former Centers for Medicare and Medicaid Services administrator from July 2010 until December 2011, is joining the Center for American Progress (CAP)**, a liberal-leaning think tank, as a senior fellow. According to a CAP

press release announcing Dr. Berwick's position, CAP officials said he will focus on "defending health care reform, ensuring its successful implementation and developing new ideas to provide better care at lower costs." At CAP Dr. Berwick joins a team of other health policy experts including CAP President Neera Tanden, former advisor to Secretary Sebelius; Dr. Ezekiel Emanuel, former advisor to President Obama; David Cutler, former advisor to President Obama; former Senator Tom Daschle and Topher Spiro, a former Senator staffer who helped draft the ACA.

Berwick headed CMS until December 2011, when he left because his recess appointment had expired. President Obama made that appointment after it became clear that Republican opposition to Berwick's nomination has made it almost impossible for him to be confirmed by the Senate. CAP was founded in 2003 by John Podesta to provide long-term leadership and support to the progressive policy movement. CAP is led by Neera Tanden and based in Washington, D.C.

More information about Dr. Berwick's new role at CAP can be found at: http://www.americanprogress.org/issues/2012/03/berwick.html

Read more about CAP at: http://www.americanprogress.org/aboutus

**3/22/12 The Commonwealth Fund issued a brief "Implementing the Affordable Care Act: State Action on Early Market Reforms".** The brief examines new state action on a subset of health insurance market reforms passed in September 2010 (known together as the "Patient's Bill of Rights") and concludes that 49 states and the District of Columbia have taken action to implement many of the consumer protections under the ACA. In fact, every state with the exception of Arizona has passed new legislation, issued a new regulation, issued new sub-regulatory guidance, or are actively reviewing insurer policy forms for compliance with these provisions.

More information on The Patient's Bill of Rights can be found at: http://www.healthcare.gov/law/features/rights/bill-of-rights/

Read the Commonwealth Fund report at: Report

**3/22/12 The U.S. House passed H.R.5, legislation to repeal the Independent Payment Advisory Board (IPAB)**, a government board authorized under ACA §3401 and tasked with finding Medicare savings. The bill, which passed by a largely party-line 223-181 vote, also overhauls medical liability laws by limiting medical malpractice awards. In order to eliminate the IPAB an offset was required because the advisory board was a key component of the ACA's cost reduction plan. The malpractice award caps provided the savings by an expected reduction in the use of health services. Many journalists and observers say that the Senate is not expected to take up and pass the bill. Earlier this week President Obama threatened to veto the legislation.

Beginning in 2013, the IPAB is charged with recommending policies to reduce the rate of growth in Medicare spending, while not harming beneficiaries' access to or the quality of needed services. Starting in 2014 the IPAB may submit recommendations to Congress every year on how to best improve quality of care for Medicare beneficiaries while slowing cost increases. IPAB is prohibited from recommending changes that would ration care, increase costs for beneficiaries, reduce benefits, or change eligibility. IPAB recommendations only take effect if Medicare cost growth exceeds cost growth targets and Congress fails to act to reduce Medicare spending.

Read H.R. 5 at: H.R. 5

**3/22/12 HHS announced that health insurance premium increases in nine states have been deemed unreasonable under the rate review authority** granted by §1003 of the ACA. After independent expert review of the rate, HHS determined that two insurance companies have proposed unreasonably high health insurance premium increases in nine states (Arizona, Idaho, Louisiana, Missouri, Montana, Nebraska, Virginia, Wisconsin, and Wyoming). The excessive rate hikes would affect over 42,000 residents in the nine states. Because the insurers would be spending a low percentage of premium dollars on actual medical care and quality improvements, and because the justifications were based on unreasonable assumptions, HHS determined that the requested rate increases, as high as 24%, were unreasonable.

The rate review program requires that insurers seeking rate increases of 10% or more for non-grandfathered plans in the individual and small group markets publicly and clearly disclose the proposed increases and the justification for them. Such increases are reviewed by either state or federal experts (in instances where states do not have such resources) to determine whether they are unreasonable. Although the ACA does not grant HHS the authority to block a proposed rate increase, companies whose rates have been determined unreasonable must either reduce their rate hikes or post a justification on their website within 10 days of the rate review determination. As laid out in the final rate review regulation, HHS will conduct rate reviews in states that do not have a rate review program deemed effective by HHS. However, most rates are reviewed by states and many states have the authority to reject unreasonable premium increases.

**HHS also released a report** showing that since the rate review program took effect in 2011, health insurers have proposed fewer double-digit rate increases. States have also taken an active role in reducing rate increases; since the passage of the ACA, the number of states with rate review authority increased from 30 to 37. Under the rate review program insurance companies must publicly disclose and explain their increases, and more than 180 rate increases been posted publicly and are open for consumer comment on companyprofiles.healthcare.gov.

Information on these specific determinations is available at:
http://companyprofiles.healthcare.gov/
Read the rate review report at: http://www.healthcare.gov/law/resources/reports/rate-review03222012a.html
General information about rate review is available at:
http://www.healthcare.gov/law/features/costs/rate-review/

**3/21/12 Georgetown University's Center for Children and Families released a new fact sheet that examines the ACA's success in improving access to preventive care for children**. More than half of American children (54.1%) have gained or maintained access to preventive care services as a result of the ACA. Millions of children already have access to preventive care at no cost through their state Medicaid or CHIP program. §2713 of the ACAhas improved access to care in private plans by expanding the quality of preventive services provided and removing cost barriers for families.

The ACA expands access to preventive services in new, "non-grandfathered" private insurance plans in two ways. New plans, as of September 23, 2010, must: 1) cover all preventive services as defined by the Bright Futures guidelines of the American Academy of Pediatrics, and those receiving grades of A or B from the U.S. Preventive Services Task Force; and 2) provide preventive services at no cost to enrollees (no copayments, deductibles, or coinsurance for defined, preventive services).

Because of the ACA:

- More than 1 in 6 U.S. children (18.5%) now have access to additional preventive services through their insurer.
- More than 1 in 8 (13.7%) of the nation's children can now receive preventive services at no cost to their families.
- North Dakota, Massachusetts, Minnesota, New Jersey and Iowa have the highest proportion of children receiving each of these new benefits in private plans.
- In Massachusetts, 242,930 children with private coverage are receiving new preventive benefits without cost-sharing and 327,427 children with private coverage are receiving a new prevention benefit as required under the new ACA guidelines.

To read the Georgetown fact sheet, visit: Fact Sheet

For more information on preventive services under the ACA, visit: Services

**3/21/12** The State Health Access Data Assistance Center (SHADAC) held a **webinar sponsored by the Robert Wood Johnson Foundation called "Predicting the Effects of the ACA: Understanding Microsimulation Models for Cost and Coverage."** In this webinar Dr. Jean Abraham, Assistant Professor of the Division of Health Policy & Management at the University of Minnesota, reviewed five major microsimulation models discussing their key components, similarities and differences, and highlighting questions states should consider when contracting for or using modeling outputs. Microsimulation models can be used to inform policy decisions raised by the ACA. They are important tools for estimating the potential impact of public policies on the behavior of individuals and/or organizations with respect to one or more outcomes (cost and coverage often being the focus). Their use by individual states is particularly important because each state starts with very different political, social and economic circumstances, and states have considerable flexibility in how they will implement the many ACA provisions. Dr. Abraham was joined by Danielle Holahan, Project Director for Health Insurance Exchange Planning in New York State. Ms. Holahan shared New York's experience working with a microsimulation vendor and highlighted key issues for other states.

View the webinar at: Webinar
For information on SHADAC, visit: http://www.shadac.org/

**3/20/12 HHS announced that over 45 million women can receive preventive health care services with no cost-sharing under §1001 and §4104 of the ACA**. This includes 20.4 million women with private health insurance and 24.7 million women with Medicare. Women with private insurance do not have to pay for preventive services such as mammograms, cervical cancer screening, prenatal care, flu shots, regular well-baby and well-child visits. In August 2012, well-woman visits, domestic violence screening and breastfeeding supplies will also be included. In addition, because of the ACA, more than 1 million young adult women have obtained health insurance. By 2016, 13 million more women of all ages will receive health care coverage. These women would be uninsured without the ACA.

Read the press release at: http://www.hhs.gov/news/press/2012pres/03/20120320a.html
Read the research brief at: http://aspe.hhs.gov/health/reports/2012/ACA&Women/rb.shtml

## Upcoming Events

**Integrating Medicare and Medicaid for Dual Eligible Individuals Open Meeting**
April 9, 2012, 10:00 AM - 12:00 PM
State Transportation Building, Conference Rooms 1, 2, & 3, Second Floor, 10 Park Plaza, Boston

The purpose of this open meeting will be to discuss next steps in the State Demonstration to Integrate Care for Dual Eligible Individuals, following topical workgroup and other activities

occurring in March.

Attendance is welcome from all stakeholders and members of the public with interest in this proposed Demonstration. Reasonable accommodations will be made for participants who need assistance. Please send your request for accommodations to Donna Kymalainen at Donna.Kymalainen@state.ma.us.

**Insurance Market Reform Work Group Open Stakeholder Meetings**
The Insurance Market Reform Work Group, co-chaired by the Health Connector and the Division of Insurance, is hosting a series of open meetings to solicit feedback on a range of topics under its purview. The meeting schedule and proposed topics are highlighted below. If any interested persons are unable to attend the meetings in person, they can participate in the session by calling the number below. We highly encourage people to attend in person as the acoustics in the Hearing Room can be difficult.
Dialing Instructions:
Dial 1-877-820-7831
Pass Code 9630386# (please make sure to press # after the number).

**Follow-up meeting on Essential Health Benefits approach and options**
April 6, 2012
10:00 - 11:30 a.m.
1000 Washington Street, Boston
Hearing Room E, DOI Offices

**Follow-up meeting about research to study the impact of ACA changes to the size of the small group market; and Changes to rating factors (e.g., group size adjustment, age bands, etc.)**
April 27, 2012
10:00 - 11:30 a.m.
1000 Washington Street, Boston
Hearing Room E, DOI Offices

**Potential ACA changes including open enrollment/special enrollment, eligibility appeals, termination, uniformity of forms**
May 11, 2012
10:00 - 11:30 a.m.
1000 Washington Street, Boston
Hearing Room E, DOI Offices

**Other issues (TBD)**
May 25, 2012
10:00 - 11:30 a.m.
1000 Washington Street, Boston
Hearing Room E, DOI Offices

Bookmark the **Massachusetts National Health Care Reform website** at: http://mass.gov/national health reform to read updates on ACA implementation in Massachusetts.

Remember to check http://mass.gov/masshealth/duals for information on the **"Integrating Medicare and Medicaid for Dual Eligible Individuals"** initiative.